COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PHARMACY TAC

February 10, 2021
1:00 P.M.
(All Participants Appeared Via Zoom or Telephonically)

APPEARANCES

Ron Poole
CHAIR

Matt Carrico
Paula Straub
Rosemary Smith
Meredith Figg
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(Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

AGENDA

1. Recommend a reimbursement model for:
   a. Specialty pharmacy: From the attached document: The mean specialty drug cost of dispensing was $73.58 (interquartile range $40.12 to $86.48) for specialty pharmacies, defined as pharmacies with at least 10% of their prescription volume from specialty drugs. For the purposes of this study, specialty accreditation status, pharmacy format (walk-in or central fill), and other characteristics were not used to define a respondent as a specialty pharmacy.
   b. Compounded prescriptions.
      • Non Sterile Compounding

SIMPLE: There are 3 types of simple nonsterile compounded preparations (NSCPs):

1. The NSCP has a USP compounding monograph. There are just over 170 USP compounding monographs.
2. The NSCP appears in a peer reviewed journal article that contains specific quantities of all components, compounding procedure and equipment, and stability data for that formulation with appropriate Beyond Use Dates (BUDs).
3. Reconstituting or manipulating commercial products that may require the addition of one or more ingredients as directed by the manufacturer. This type of simple NSCP does not require any further documentation such as a Compounding Record.

MODERATE: There are 2 types of moderate NSCPs:

1. The NSCP requires special calculations or procedures, such as calibration of dosage unit mold cavities, to determine quantities of components used in the NSCP or in individualized dosage units.
2. The NSCP does not have specific stability data available. For example, mixing two or more manufactured cream products when the stability of the mixture is not known.

COMPLEX: The NSCP requires special training, environment, facilities, equipment, and procedures to ensure appropriate therapeutic outcomes. Examples of complex NSCP may include some transdermal dosage forms, modified-release NSCPs, and some inserts and suppositories for systemic effects.

- o Simple (AWP of Active Pharmaceutical Ingredients (API's) + $15.00)
- o Moderate (AWP of API's + $25.00) (2 to 3 API's)
- o Complex (AWP of API's + $40.00) (4 or more API's)
  - • Sterile Compounding

Low-Risk with ≤12-hour Beyond Use Date (BUD) (Non-Hazardous) (AWP of API's + $30.00)
Low-Risk (Non-Hazardous) (AWP of API's + $30.00)
Medium-Risk (Non-Hazardous) (AWP of API's + $40.00)
High-Risk (Non-Hazardous) (AWP of API's + $50.00)
Hazardous Drugs (AWP of API's + $75.00)

2. Appeal process for claims not reimbursed per contract or below acquisition cost
   a. Appeal to drug manufacturers
   b. Appeal to MCO PBM

3. The dispensing fee is a recommended reimbursement rate per prescription based on different prescribers prescribing limitations. Pharmacy will not be penalized for dispensing multiple times per month due to providers' prescribing limitations

4. The audit provision of the contract will be in accordance to Kentucky PBM audit statutes and will be the same for all pharmacy types. One pharmacy type cannot have a no audit contract and other types have audits in their contracts.

** Exceptions can be made when true audits are justified such as:
   a. Suspected over dispensing of controlled substances
   b. Suspected drug diversion
   c. No typing or clerical errors will be eligible for audits
      I. Invalid days supply had to be entered due to insurance or PBM data entry limitations
      ii. No invoice or inventory comparison audits

<2020 Cost of Dispensing Study NACDS-NASP-NCPA-COD-Report-01-31-2020-Final.pdf>

5. Medimpact encouraged to pay for low cost OTC medications to assist Kentuckians in affording much needed nutritional supplementation and medication assistance. Increasing the OTC formulary will save the cabinet by paying for OTC products that are cheaper than legend drug alternatives.

6. MCO not paying for pain medications unannounced

7. Adjourn

MR. POOLE: From what I can see here, we've got everybody except Jill as far as our PTAC Committee. I just want to welcome everybody. I call the meeting to order.

It's kind of a lengthy agenda but I think we can get through it. Our biggest goal, we want to make recommendations that I will present or somebody present to the MAC at their next meeting.

And, then, we have Jessin on here today and maybe Fatima is on here, too - I don't see her yet - to where we could get some answers on what's going on currently right now but that's later in the agenda.

So, the first item is to recommend a reimbursement model for specialty pharmacy. I have a gentleman on the phone who has raised his hand to say something because he does have a specialty pharmacy.

So, Chris, if you can unmute yourself and express your thoughts on the reimbursement model for specialty pharmacy.

DR. HARLOW: Thank you so much, Chair Poole. So, really I'm coming today because we're seeing an issue with some Hepatitis C treatment. So, our pharmacists----

MS. HUGHES: Chris, could you identify yourself just for the court reporter, please?

DR. HARLOW: Absolutely. My name is Chris Harlow, the Director of Pharmacy Services at St. Matthews Community and Speciality Pharmacy.

MS. HUGHES: Thank you.

DR. HARLOW: Thank you. So, at St. Matthews Pharmacy, we have a robust substance use disorder treatment program. And because of that treatment program, really we've been doing a lot of care coordination and screening for all the treatment for patients with Hepatitis C, but we're starting to see a concerning trend, particularly with the reimbursement of the brand name medication Epclusa.

So, I'm really coming today to make a recommendation that we add the brand name Epclusa as the preferred agent on the MCO Medicaid PDL.

Right now, we're seeing the Epclusa authorized generic and the reimbursement rates are really pretty horrific in terms of trying to get patients access. Providers really do prefer Epclusa as the medication over Mavyret for some

clinical reasons which I'm happy to go into if you request that, but really we're seeing more prescribers prefer Epclusa, but, unfortunately, we're just not able to get patients onto the Epclusa because of the concerned authorized generic.

So, we are making a recommendation that we add the brand name Epclusa as the preferred agent on the MCO Medicaid PDL.

MR. POOLE: And, Jessin, if you don't mind to make a comment there about how often does the - of course, the DMRB has not met for years but the Pharmacy and Therapeutics Committee, how often do they meet?

DR. JOSEPH: That's a great question, Chair Poole. Dr. Harlow, first of all, thank you for bringing this to our attention.

This is where the P&T Committee comes into play. I think the concern that you're bringing up is well-documented here. I'm certainly going to take this back, but this is really something where we would be discussing with providers, pharmacists, manufacturers, the general public really at the P&T meeting.

So, Chair Poole, I think this is where you were going. We meet four times a year,

the P&T Committee does for the State of Kentucky. Right now, as you might know, it's the fee-for-service PDL that's really dictating where the preferred and non-preferred status of these products are for the MCOs as well.

I was just pulling it up. Give me two seconds and I'll tell you that the Hepatitis C products are reviewed as a class at the March P&T meeting. So, this coming, March, I believe it's the 18th, is when the class will go up for review.

And, again, this might be a good avenue for me to just kind of speak on P&T in general for everybody because, again, the PDL will now go off the P&T.

So, Magellan is contracted with the State to handle the P&T Committee. And, so, what they do is they solicit bids from manufacturers for rebates essentially and there is a process in terms of ensuring that we do have a federal rebate for all covered products. So, the Epclusa brand is on there, Mavyret is on there, Epclusa authorized generic is on there as well.

From there, we will evaluate both cost and clinical effectiveness and determine where the product needs to lie.

We take this information and we essentially present this information to the P&T Committee. Again, Magellan is contracted to do this.

So, their staff pharmacist for the State is the one who really runs the P&T Committee meeting, and the committee themselves will be able to take a look at the cost sheets. They'll be able to take a look at the clinical considerations and, then, they will make the final recommendation to the Commissioner who is the final sign-off for everything.

And, so, Dr. Harlow, one thing that I can recommend is we certainly would love to have you at the P&T Committee to speak on this. I think the P&T Committee would appreciate it as well.

To be honest, the fee-for-service population is a lot smaller than the MCO one, so, we don't get as much turnout as we would like, but I think, again, the move to the single PDL, our expectation is our participation is going to increase.

So, if you're amenable to that, I will certainly add you to the list. I think you'll just have to fill out a short form designating exactly what you said really, where you work and your

position and, then, we can make sure you're on the list.

DR. HARLOW: Thank you very much. I appreciate that.

DR. JOSEPH: Certainly.

MR. POOLE: Thanks, Chris. Okay. As far as setting a reimbursement model or having a recommendation for - and I apologize. I'm working from home and I have two dogs and, of course, the UPS driver just pulled up, so, they will be barking here. So, I apologize.

But, anyway, in all the documents that are available out there, and I've provided those and sent those to all of you, that range that's in that 1a there, that $40.12 to $86.48, that was the highs and the lows for specialty pharmacy dispensing fees.

And, of course, I've spoken to Jill Rhodes, now the Board of Pharmacy president, about having issues with specialty pharmacy and how much requirements and REMS are required to get to even to where they can dispense the product. So, there's a lot of expense that goes along and the administrative fees with this.

So, I didn't know if somebody

had a recommendation. I've been trying to do my research behind the scenes. I know Jill McCormack had made some recommendations before on her studies.

So, anyway, would anybody like to comment on that reimbursement model for a specialty pharmacy as a recommendation to the MAC?

DR. ALMETER: This is Philip Almeter. I ran this by my team on the specialty pharmacy at UK and that sounded very consistent to what we are seeing in some of the market----

COURT REPORTER: Can you speak up, please?

DR. ALMETER: Yes. This is Philip Almeter with the University of Kentucky. I ran that number by our team and they said that that's within the range of what we're seeing with many payors.

MR. POOLE: And you're talking about the $73.58?

DR. ALMETER: Correct.

MR. POOLE: Okay. Paula or Matt or Rosemary or Meredith, do you have a comment on this?

MR. CARRICO: This is a little bit out of my expertise. I wouldn't mind hearing

what Chris Harlow has to say since I know he's also a specialty.

MR. POOLE: Right.

DR. HARLOW: Thank you. So, St. Matthews Specialty Pharmacy had sent over a recommendation October 24th. I'm not sure if you guys have that available or not, but our recommendation on specialty was Wholesale Acquisition Cost plus 0%, dispensing fee - I'm sorry - flat or 0% plus a dispensing fee of $50.

And, then, number two is that Average Sale Price, ASP, plus 6% on the blood-clotting factors and that was based on research that we have done nationally with Medicaid plans across the U.S.

MR. POOLE: Chris, do you mind to elaborate on what your requirements are to educate those of us who are not specialty pharmacy?

DR. HARLOW: As far as how to classify specialty medications?

MR. POOLE: Well, as far as time constraints, time demands, administrative work that you put into each claim.

DR. HARLOW: Sure, absolutely. I think the most important thing to remind everyone

is to be a specialty pharmacy requires one or not two specialty accreditations. So, if you look up national accreditations like ACHC, and, you're right, obviously there's time and expense there that's really not factored into dispensing fees with your traditional community-based pharmacy, plus the care coordination.

You're using pharm technicians but you also may be using patient care coordinators, so, it's additional staff to ensure that patients get access to the high-dollar medications, plus you factor in shipping.

A lot of the contracts do require pharmacies to be closed door and do shipping. So, this is the standard across specialty pharmacies that they do cold chain shipping, then, you have processes in place where you test the shipping. It's not just throwing it in to a mailer and sending it out. It really does require use of controlled temperatures and making sure you're testing those controlled temperatures.

So, there are a lot more expenses going in than you typically see with your traditional community pharmacy.

MR. POOLE: Do you feel that if

we went with a standard of the $73.58 that was done with a study that was approved by NACDS, NCPA and APHA, do you feel that in order to streamline it and I guess make it as simple as possible, do you feel that would be acceptable on the blood-clotting factors also?

DR. HARLOW: The blood-clotting factors we made a recommendation based on just national averages, but are you saying do a WAC plus zero plus the $73.58 dispensing fee? I'm sorry.

MR. POOLE: Yes.

DR. HARLOW: Okay. Yes. We were making a recommendation to be conservative that $50 to $75 we thought was reasonable.

MR. POOLE: Okay. Any other comments from any of the committee members? And if there are no comments, is there any action that you would like to take?

DR. JOSEPH: Chair Poole, is that for me or is that for the committee?

MR. POOLE: That's for the committee to either make a motion, or if a motion is not made, then, there's no action taken on this topic and we move on to the next item.

DR. ALMETER: So, does a motion

need to made to actually recommend the $73.58?

MR. POOLE: Yes, sir.

DR. ALMETER: I'd like to motion to recommend that.

MS. STRAUB: Second that.

MR. POOLE: Any further discussion? All those in favor, say aye. Any opposed? Motion carried.

What we came up with before when we were talking about the lesser of, what we'll do, it will be that NADAC, that whole breakdown of everything.

So, it will be a standardized recommendation along with what we had already submitted for just regular pharmacy dispensing fee. So, it will be the same, and I'll present that to Sharley because it has already been voted on and approved.

DR. FIGG: Ron, this is Meredith. I just have a question. So, is the specialty pharmacy by definition going to be with at least 10% of their prescription volume being specialty drugs or are we going to have any parameters as far as accreditation and that sort of thing before that reimbursement applies?

MR. POOLE: That's entirely up to this committee. If we want to make a requirement on having to be accredited in order to qualify in the specialty pharmacy in this Medicaid Program, that's what we can decide on.

So, if you would like to open up the discussion on that and just express your opinion.

DR. FIGG: I'm kind of like Matt. This isn't my wheelhouse, so, I'm not necessarily saying I'm for it or against it. I was just kind of clarifying the definition of specialty pharmacy, specialty drug and that sort of thing.

DR. ALMETER: I can, if I may, speak a little bit about this because I've worked from independent to health system to specialty, and I know that specialty drugs are not limited to specialty pharmacies. I'll say that.

However, I think that the distinction that I think Chris was referring to earlier with accreditation, so, the specialty pharmacy hierarchy has URAC and ACHC accreditation because after doing URAC, some payors wouldn't allow us to dispense unless we had an additional accreditation.

I'm really agnostic to any accrediting body. We only do it because PBM's are asking it, but it is a nice standard to fall on that if you received an accreditation from just a single group, it's a nice way to distinguish it, but I can also see there being additional work because there is going to be additional prior authorization work, say, on an independent pharmacy that is dispensing a specialty drug. You're still doing a lot of work just to get that dispensed to get it through. It's not like an easy claim.

So, I can see there being need for some openness there with that kind of a dispense fee. That's my input.

DR. FIGG: Philip, thank you. I agree. I think independent pharmacies are perfectly capable of doing this and wouldn't want to be excluded just because they don't have the accreditation. Thank you for that input.

MR. CARRICO: I'd like to echo that. I don't think accreditation should be necessary because you just never know when you're going to run into some of the situations we've run into in the past where people start saying certain drugs are specialty when I guess in my opinion they

definitely aren't specialty, and, then, it becomes a subjective matter.

I think it might be easier and better just if you're a pharmacy in Kentucky, you can dispense.

MR. POOLE: Okay. Sounds good. Any further comments on that?

DR. JOSEPH: I think I understand the concern here. So, really, if we're not defining specialty pharmacy, then, we would need to define a specialty drug list, correct?

MR. POOLE: Yes, sir. I would say that at least the P&T Committee needs to have the formulary set for specialty pharmacy drugs. Is that as defined as you would like it or at least give you some direction there?

DR. JOSEPH: Yes, I think that will be fine. Again, I completely understand. Right now, we don't capture information around who is a specialty pharmacy and who isn't.

And, so, that would be one way we can go and start capturing that information, but based off of what Dr. Figg and Mr. Carrico have said, we can certainly do the other approach which is define a specialty drug as a specialty drug and tie

the reimbursement that way.

MR. POOLE: Okay. Sounds good. Sharley, if you could move up the agenda a little bit there so we can see everything under b.

Under compound prescriptions, what I've got underneath here is just one description of non-sterile compounding.

I looked at several accrediting bodies out there that had some information on their websites as far as reimbursements that are being approved in other states.

So, I just put it on here just for information purposes to give everybody at least something, a guideline to go by here.

Obviously, I used to do sterile compounding twenty years ago but just the market wouldn't support it to continue on and keep up the standards or keep up my facility. There just wasn't enough business in my area, but on the non-sterile side, I've been compounding for twenty-seven years.

Obviously, it's not a secret that the FDA is trying to put a lot of pressure on compounding right now. And one of the most rewarding experiences for me has been working with hormone replacement therapy patients because that's where you

get comments like thank you for giving me my wife back or thank you for giving me my husband back and people that have gone through some major menopausal areas in their life. Some people can go through the change of life and it's not an issue and, then, others, it's a complete transformation that you don't even recognize the person.

Anyway, I tried to put it from a simple compound to a moderate to a complex on the non-sterile side and, then, the sterile side, I've got that down below there.

So, I just wanted to get people's - and, of course, I just put AWP. Obviously, we can put cost plus whatever.

Again, we can use some of the same lesser-than language that's in our first recommendation because, again, the main thing is if you're ordering chemicals from the right sources, which there's plenty of them out there, they should assign an NDC. They should assign cost or even an AWP and it should be fine to create a formulary of those main chemical companies that are trusted.

I have vetted so many of them over the years that basically the two that I deal with say that they turn away more chemical than they

accept because of their high standards.

So, anyway, I wanted to get other people's comments on the compounding.

DR. ALMETER: This is Philip again. I agree with what you said, Ron. I think, yes, the FDA puts pressure on this part of our industry heavily and far more in favor of FDA-approved manufacturers.

However, this is I think a key piece of our practice and what little bit of time I have spent in outpatient compounding pharmacies, the patients that do find their way there, they go there because they don't have another choice.

And I think there is a potential that keeping supporting this direction by enhancing dispense fees keeps the door open to future research in pharmacogenomics and individualized, personalized dosing, that we don't really have another avenue besides something like this. So, I'm supportive.

I will say one thing. I do like if we do something like lowest of logic, we continue to do the same thing, not that 340B is as big in here, by continuing to remove that from the lowest of logic. That's all.

MR. POOLE: Right. And before anybody else speaks, we get periodically discharges from U of L pediatrics. So, we're converting usually adult cardiac drugs into dosage forms for premature births or even infants.

I've had one I call him my Cardiac Kid. From day one, I've had him since, well, then, it was Kosair's. And, recently, in the last two years, he was able to get a heart transplant. All the compounding that we've done for him over the years, I feel like we've had a hand in this now seventeen-year-old success as just enjoying life.

So, obviously, I'm very biased because I've been compounding for so long but there's some really good outcomes from this.

MS. STRAUB: This is Paula. I can speak more from a provider perspective in that I get calls all the time from providers where they say access is an issue for compounded products.

So, anything we can do to keep pharmacies being able to do this as far as reimbursement, I think we can get some provider buy-in on that because this is a real problem for them, where to send patients. So, yes, it is.

MR. POOLE: And I will comment

further for Jessin and the people from Medicaid. In the last three years, four years, the Board of Pharmacy, which I just went off of December 31st, put forth a huge effort to make sure some of the tragedies that's happened in compounding like NECC in Massachusetts, and you can name several others but that's the worst one, that that's not going to happen in Kentucky.

And, believe me, there has been a large reduction in the number of compounding labs and pharmacist compounders in Kentucky and it's not because of, hey, the Board of Pharmacy has something against compounding. It's just there's a standard that has to be met and that's going to be met. And if you don't want to meet those standards, then, you don't need to be compounding anymore.

So, I feel very confident - of course, again, I'm biased because I was on the Board during that whole period - to where compounding has been greatly improved in Kentucky. So, the people that are doing the compounding now are going through all the standard recommendations. They're going through the USP 795, 797 standards. USP 800 obviously is followed but not in as a regulation.

Anyway, I just want to bring

that up because I really feel like the quality and the people who are - to me, I always refer to them as shirt-tailed pharmacists who find a way or an avenue to do the bare minimum and those type people anymore are gone.

So, I don't know if Jessin realized that or not but it is. The people who are involved, whether it's sterile or non-sterile now, are in it for the right reasons and they're abiding by all the requirements by the Board and the national organizations and standards.

DR. HARLOW: This is Chris Harlow. So, we do non-sterile compounding at St. Matthews Pharmacy and we see a fairly large pediatric population and this pediatric population is serviced by Kosair in Louisville and we also have patients at Cincinnati and Indianapolis that live here in Louisville that travel to these children's hospitals to seek care and many of these individuals do require compound medications. So, I appreciate the opportunity that we're looking at this.

One of the recommendations that we would like to recommend is utilizing the NCPDP's billing using the Level-of-Effort codes, so, 11, 12, 13 and 14 based on complexity and, then, doing a

compounding fee on top of a dispensing fee, utilizing those codes.

All we're really asking for is that we're able to essentially bill for the service and we bill for the service through that mechanism.

It's okay if we're just reimbursed based on the cost of the drug. We're okay with that if you use something like NADAC, but we just want to be able to bill for the service of actually compounding, so, ranging from $12.50 to $50, depending on the complexity.

MR. POOLE: Okay. Chris, do you mind to spell those out to us, the level of complexity, if you've got it right in front of you?

DR. HARLOW: So, it's a level of effort. It's 11 through 14 - 11, 12, 13, 14 - and it's billed based on the pharmacy's - utilizing the risk I believe that you have here on your screen.

So, the pharmacy will bill at appropriate level of effort. A level of effort 11, it's based on number of minutes to compound is how we have it listed. So, fifteen minutes, thirty minutes, forty-five minutes, sixty minutes.

Again, I can't speak on behalf of sterile compounding, so, I apologize, but we have

recommended compounding fees of $12.50, $25, $37.50 and $50 based on level of effort.

MR. POOLE: Could you give me those again?

DR. HARLOW: Yes, $12.50, $25, $37.50 and $50. Thank you.

MR. POOLE: Okay. Thank you. Now, if you could scroll back up, Sharley. Do we have an action that the committee would like to take on a recommendation, or is this something that we could do our homework and really come up with a standard that we want to recommend, or do you feel like we've got some good bones right here to work with? Rosemary, you've been awful quiet.

MS. SMITH: This is a little out of, as Meredith said and Matt, it's a little out of my wheelhouse in retailing and most of our independent KIPA members, but I'm willing to listen to everybody else. And I think listening to what Chris has recommended, it's been very good for what he has recommended to us.

MR. POOLE: Okay.

DR. ALMETER: I would like to second that. This is not my area of expertise, but if those who are more comfortable like you or Chris

have some information, I'll support it. I just want it to be a solid dispense fee for compounding.

MR. POOLE: Okay.

MR. CARRICO: Ron or Chris, were those recommendations just for non-sterile?

MR. POOLE: Yes. He didn't have anything for sterile compounding.

MR. CARRICO: I'm fine with those, but do we have anyone with insight on sterile because I don't really know what it takes overhead-wise and time-wise for sterile compounding, and I don't want to approve something blindly that ends up really hurting them. Does anyone on this call have any insight on sterile compounding or do we know anyone we can contact before the next meeting?

MR. POOLE: That's what I was going to say. If we want to, I can work with the people that I know in sterile, and, of course, I'll talk to Ben Mudd who is on the phone here with us with KPHA and get some key players in the sterile compounding area and just send out a survey to them and get a more standardized.

And Chris and I can work and get this language down to a true standard on this to where, when I come back to the next PTAC meeting,

we'll have something concrete right in front of you that should have been vetted properly throughout more compounders and a better recommendation.

That's what I think we need to do unless somebody wants to comment further on it.

MR. CARRICO: Are you talking just to put on hold all compounding or make a motion for non-sterile now and do research for sterile for next time?

MR. POOLE: If you're comfortable with making a motion on the non-sterile. I just think we need to certainly poll or survey the sterile compounders out there and get a better understanding and even maybe have somebody on the line next time that can explain it and what their logic is behind what they as a group proposed.

MR. CARRICO: I would be fine making a non-sterile motion except this looks so detailed, I don't even know how to say the motion.

MR. POOLE: Like I said, we're meeting again two months from now. So, I think if we could table it until then and let's get everything the way it needs to be.

MR. CARRICO: Sounds like a plan.

MR. POOLE: Okay. Is that alright with everybody? All right.

If you don't mind to move on down, Sharley. Jessin, do you have any comments or do you even know with Medimpact what kind of appeal process they have proposed or have they proposed one? I just wanted to ask you first.

DR. JOSEPH: Not necessarily to the specific reimbursement I guess benchmark, but part of the RFP is they do have to have an appeals process available. And, so, that will exist. Whether or not - I'm sorry. That is going to exist regardless.

It's also in the MCO contract to have an appeals process. And, then, really, just dependent on the pricing benchmarks which, again, I don't - that DMS has not yet finalized, there are different appeals processes for those benchmarks, right?

So, for something like WAC, we don't control that cost. So, there really is no mechanism. Something like NADAC, there is a process for the NADAC team to go back and evaluate whether or not the NADAC is appropriate, but there are appeals mechanisms in place; but from Medimpact's standpoint,

it's within the contract.

MR. POOLE: Okay. Do you know, with our already existing appeal processes in Kentucky that's been passed, is Medicaid exempt from those?

DR. JOSEPH: That's probably a question for DOI. I don't know.

MR. POOLE: Okay. I did not think that Medicaid was, but go ahead, Matt, if you want to comment on it.

MR. CARRICO: Were you referring to fee-for-service or MCOs?

MR. POOLE: MCOs.

MR. CARRICO: MCOs, no. You can do the current appeals process with MCOs. I don't think it applies to fee-for-service, though.

MR. POOLE: Okay. I put it on there and I appreciate your comments, Jessin, because, obviously, if you're a pharmacy owner, whether you're a chain or independent, either one, and you start seeing so many claims underwater or below your net cost, then, you want to be able to have some resource to straighten the situation out and it has helped over the years to be able to have that mechanism.

So, is there further discussion on this topic here?

MR. CARRICO: If we're going to go with - if it ends up going with a NADAC plus, I just wonder. I've had probably two or three in the last year on fee-for-service that I noticed were noticeably below what I was being able to acquire a drug for, and I reached out to Jessin and he helped show me the ropes on doing a NADAC appeal and I did, and just the answer I get back was no.

I called multiple people that I knew used the big three wholesalers and checked TRxADE which is just a search for tons of side wholesalers and NADAC was incorrect.

I'm not going to say it's going to happen often but it did happen. So, I don't know what we need to do or puts it in place for if and when it happens again. Fortunately, I didn't dispense that drug to too many people, but if it's a common drug, it's really going to add up quickly if that scenario ends up happening.

So, I don't know. I feel like we do need to address some type of an appeals process for something like that. What it is, I don't know. I'm open to suggestions. I guess it's the pharmacist

in me that just assumes the worst things are going to happen if we don't address it ahead of time.

MR. POOLE: Jessin, I just have an idea that I had before we had the meeting today. I guess would it be useful to request that Medimpact have an appeal process that works with all of our lesser-of logic in the pricing, so, therefore, whether it's NADAC, whether it's WAC, whether it's whatever all the way up and down through there, that they have a process for us to get an answer and to work with those because we all know that each one of those, even though some may try harder than others, but each one of those standards, those pricing standards are dated.

They're already one month behind, two months behind or greater. So, that's where the problem lies is that price updates don't get put in very quickly on a lot of those pricing standards and, then, of course, in NADAC, I think it's quarterly that they do their evaluation. I may be wrong on that but that's what I thought I remember I how they figure the NADAC pricing.

So, with that in mind, knowing that every standard we're looking at is actually dated material, just like the cost-of-dispensing

study that I presented. That was a 2018 study but it was published in 2020.

Anyway, if you want to make a comment on that, Jessin.

DR. JOSEPH: Sure. I agree with you. There are lags in these; but if NADAC captures a lag, if they've captured that the information is incorrect - and this is the same for manufacturers when they submit their rates to the drug databases, right, FDB or Medi-Span, whoever they're using - sometimes the manufacturers are late on submitting their price changes.

And, so, when that happens, there is an effective date for the certain price, for the actual price that it's changing to. And, so, our system should be capturing when the price changes.

Now, I don't have access and I don't think it makes sense for us to have access to when every drug falls into this specific situation, but those effective dates would be applicable to when the actual price of the drug changed.

Unfortunately, again, I don't have access. And, so, when a pharmacy, it looks like it's under-reimbursed and, then, once the date is updated within the systems - again, these are

national systems, so, nothing that DMS can control - the ability to reprocess those claims is going to be there for the pharmacy.

Again, unfortunately, I don't have a way of knowing when that is and which drugs fall under this category, but I think this is their way of saying that they're staying up to date with these drug products.

MR. POOLE: Okay. With Medimpact going to be adopting or hopefully something similar to what we recommended to DME and the MAC, obviously, we're going to need some help in all of those varying standards to make sure that there is a process for us to question it when there is a discrepancy.

DR. JOSEPH: Sure.

MR. POOLE: So, I don't know if it would do any good, or, Matt, I don't know if you want to, but just something simple as to ask Medimpact to have a process by which we can send in to them or agencies, or in the case of chain pharmacies, their agencies, to send in appeals on all of those different pricing standards, whichever one it fits under.

MR. CARRICO: It would be nice -

I don't know how we'll do it - but it would be nice if we're going to be doing NADAC and they say no, then, like the current appeals process, they would have to show us where that drug can be purchased for that NADAC price.

MR. POOLE: Okay.

MR. CARRICO: From a place that's readily available, a wholesaler to a pharmacy in Kentucky.

MR. POOLE: That's the way our state law is on PBM appeals. So, go ahead.

MR. CARRICO: So, I think if we can kind of work it in that way. The current one I don't think addresses NADAC but we only have one plan that does it, fee-for-service.

So, we might have to do some tweaking and get that worked in with it, but I think that could be a good way. If you show me where to buy it without me having to switch major wholesalers or if it's available from a side one or something, I'm fine with that. That's fine to not have to be a smart shopper.

MR. POOLE: Okay. Any further discussion on this? And, then, if no further discussion, does anybody want to take action?

MR. CARRICO: I think the current action will be trying to figure out how to work this in with the current appeals process, and I can try to look into that between the meetings since I helped with the current setting and I will report back.

MR. POOLE: Okay. And I can help out where I can there, too, Matt, and we can get some people together to just pull - obviously, we need to pull our current laws and fit something in with them to get a good request, a motion that Medimpact wouldn't have a problem adhering to.

So, let's table that one, too, until next meeting and hopefully have some more supporting information on that the next time.

So, Number 3. This is something just real simple. Matt is the one who brought this to our attention, but the dispensing fee because nurse practitioners and other practitioners, PA's have prescribing limitations on day supply or quantities sometimes.

So, this was just a recommendation that the dispensing fee is going to be recommended on a per-prescription basis, not based off of a particular days' supply.

So, do we have any further comments on this; and if not, do we have a motion on it?

MR. CARRICO: Well, I spoke to Jessin in the interim about this, and currently fee-for-service is one dispensing fee per twenty-three days. If Jessin wants to elaborate more on why it's set up that way.

I mean, I get that they're trying to prevent people from gaming the system and billing for a tablet a day to get a dispensing fee per day. I don't think people are going to do that.

But in my situation, especially if you're working with Suboxone patients, a lot of them get a week's supply. Where I work, there's a lot of nurse practitioners, everything is narcotics because they have problems with people, they'll end up making them two weeks at a time on anything that's a controlled substance.

And, then, there's a number of drugs that no matter how you do it, it's going to be less than twenty-three days. One of the two most common directions for an Abuterol inhaler is a sixteen-day supply, and I don't want to break even on filling someone's rescue inhaler because that's how

it is.

I just feel like there should be a different way to do this that's fair to everyone.

MS. STRAUB: What about those patients that the provider needs to see? So, they may give just a few days' supply until they have an appointment. So, I think that needs to be taken into account as well.

MR. CARRICO: Exactly. Jessin, do you want to provide any of the insight or the logic on why it was like that?

DR. JOSEPH: Matt pointed this out to me. We did some research as to why the fee-for-service system is set up this way. I think as a practicing pharmacist, you'll see that the MCOs pay per prescription.

I could not find documentation as to why we've operated the way that we have. This is part of the benefit design. So, to be honest, this decision was made years ago; and for something like this, it requires CMS approval.

So, CMS did sign off on something like this. So, if a change is made, we do need to get CMS approval on something like that.

Unfortunately, my research came up empty-handed and I'm sorry that that was the case; but just from understanding the process, I just know that it was a decision made long before I joined.

MR. POOLE: Okay. So, Matt, since you've spoken out on this, what if we at least came up with a recommendation one per fourteen days.

Now, again, I have one of the largest Suboxone clinics in my area. They moved seven clinics into one and they dispense usually a week's supply for everybody.

And, so, you're talking at least if we went one per fourteen, one per fourteen would get the majority of everybody; but on Suboxone, at least you would have two times every twenty-eight days to get a fee.

I just wanted to ask about what do you think about sticking to a recommendation of one per fourteen?

MR. CARRICO: I mean, it's better than where we're at. It would capture a lot of the scripts that I have concerns about, especially with the inhalers and whatnot. It still would leave people with seven days rough but it's better than where we're at. So, beggars can't be choosers. I

wouldn't mind hearing other people's opinions that's on the call.

MR. POOLE: Ben, why don't you, since you're on here and you just came off running a store for many years.

DR. MUDD: My problem, is there a possible way in the claims process to put some kind of override in and it would fall on the pharmacist at that point to somehow be able to track that, but to put in some kind of override code that you acknowledge there's a reason for doing such, for asking for multiple fills per month, if that prescription comes across Matt's computer and you see that there's not a dispensing fee, you can put in some kind of code that would allow for and rebill for a second dispensing fee within that twenty-three days.

MR. POOLE: Okay.

DR. MUDD: Jessin, is that something that is at all possible?

DR. JOSEPH: So, I think it's possible. I'm surprised how innovative some of these claims processes are.

I think it's certainly possible, but, again, I'm thinking from a regulatory

standpoint of CMS approval. And, so, we might need to define how we would do that and I'd have to take it back.

So, theoretically, I think it's possible but I think we have to take that back before we can agree to something like that.

MR. POOLE: Okay.

MR. CARRICO: One idea I had is I believe this year or within the last six months, NCPDP, they're able to see how much the prescription is written for as well as the quantity dispensed.

So, if we're able to say, yeah, we dispense whatever the quantity is written for, whether it's seven for seven days, then, you shouldn't be punished; but if it's a quantity seven with two refills and you just keep running it every seven days instead of running all twenty-one together, then, you would only get one dispensing fee if that's how you're doing it, if that makes sense.

I think that is, in my opinion, the most fair way because pharmacies can't help how things are written.

MR. POOLE: Okay. That's a good point. So, any further comment on that?

MR. CARRICO: Rosemary, have you

heard from anyone from KIPA on whether they're having any concerns about this or opinions or whatnot?

MS. SMITH: We haven't, Matt. That hasn't been an issue that I've heard about.

MR. POOLE: Okay. So, Matt, do you feel comfortable making a recommendation, a motion for this, or is this something that you would like to----

MR. CARRICO: I will make a motion. It's probably not going to be the cleanest sounding or looking motion.

I'd like to make a motion for the dispensing fee to be per prescription, including refills - how would I word this - to fill the prescription for the maximum amount allowed for thirty days per dispensing fee.

Does anyone have a better way of putting this than I am right now?

DR. MUDD: If we're assuming that you can track the quantity prescribed, then, you could say something - that's I think an assumption there - but if that's the case, then, you would say it's twenty-three days or more often if the quantity prescribed is less than twenty-three days, if the days prescribed is less than twenty-three days.

MR. POOLE: And just to kind of help clarify what you were bringing up a while ago, Matt, on new prescriptions, because if it's refills, there are limitations. There are prescribing limitations. So, I'm just trying to come up with a way of saying it's just on new fills.

MR. CARRICO: Jessin, if we get a motion on this, what's the turnaround time from CMS to get a thumbs-up or a thumbs-down?

DR. JOSEPH: Ninety days if I submit it the day that I get it from you all, but we'll have to take it back and see what leadership says, too. So, it's going to be a while. It wouldn't be quick.

MR. CARRICO: I'm just trying to figure out if I want to wait to try to word this better before I make a motion.

DR. JOSEPH: I would wait probably.

MR. CARRICO: Can you confirm or deny? Are they able to see quantity written and quantity dispensed now like I think they are?

DR. JOSEPH: The engine or CMS?

MR. CARRICO: No, the insurance, the PBM or whoever is processing. When you submit a

claim, are you able to see quantity written and quantity dispensed now?

DR. JOSEPH: I think that's correct, but I'm fairly certain now that everyone has updated the NCPDP formats, that shouldn't be an issue.

MR. CARRICO: Okay. Would you be all right with me tabling this, Ron, and trying to figure out how to word this properly to make sure it covers the scenarios we're talking about?

MR. POOLE: Yes, I agree. Again, we can work with Ben on that and get proper wording that we need on that. Like I said, I'd rather get it right than to try to scramble through it now.

DR. MUDD: Would it be possible, just taking it a different route here, but would it be possible to create a list of commonly-used drugs and that list could be modified from time to time by this group or someone else at Medicaid to allow for those changes?

MR. POOLE: I think that's a good possibility that that's where we go with this. So, that's the reason why I think it's important that we need to discuss this, but it might be easier to

come up with a list.

MR. CARRICO: But the list, though, you're pigeonholing yourself because what if, like someone mentioned earlier, a doctor just calls in a three-day supply on all their maintenance meds before they get seen and, then, three days later, there you are.

MR. POOLE: Right.

MR. CARRICO: So, it sounds like we have a little work to do on this topic but I think we can attack it.

MR. POOLE: Okay. Any further comment on Item 3?

Let's move on to Item 4. I just put just some supporting information on here. We do have audit laws in Kentucky on PBMs, but I just wanted to make sure that it's going to be the same for everybody.

So, whatever Medimpact, and, Jessin, you can comment on this, whatever they put in place for their audit processes, one, I would hope that they would not just issue an audit to what we see in the marketplace right now where it's just a fishing campaign.

I would really like for people

to not audit us unless there's suspicion. That's what audits should be.

So, I'm having to spend all kinds of time on audits now and we wind up in the long run getting charged back nothing but it's just busy work, that they're out fishing for somebody who has messed up on one claim or two.

So, I would really like it to spell it out to our new insurance that I would hope that our audit process will be a whole lot more fair and clean. And if there's somebody out there who they offer a no-audit contract to, I hope that that would be the same for all of us because there is that out in the marketplace now.

So, I don't think that certain types or categories of pharmacies should be able to enjoy a no-audit contract and, then, other entities have to deal with everything.

I mean, I understand if somebody is doing something illegal or unethical, it's not that hard for them to get caught, but I just really am tired of the fishing expeditions to where it results in the same thing every time and I've spent hours and hours on it. I would rather concentrate on patient care.

Anybody else have any other comments on the audit provisions?

DR. ALMETER: I second what you said. The audits these days which in many cases I've seen are more aligned with vertically integrated PBM's where if you're not part of that vertical integration, you can get audited a whole. There's not a lot of findings but there's costs to your own business for the time offline spent with the auditor going through prescription after prescription.

So, any more transparency we can add in this process I welcome.

MR. CARRICO: To add to this, I wouldn't mind making documentation easier. I know one PBM, if you need the doctor to clarify, yes, this is what I meant, like, I had a Trulicity sent over, I e-scribed quantity four and I had to get the doctor to verify that he meant four syringes.

I don't know what else they would have meant, but it had to be written on the back of the doctor's prescription, and I had to go drive an hour and a half to Lexington just to pick this up.

So, I wouldn't mind to making documentation for something that gets audited easier

for us as well.

MR. POOLE: Okay.

MS. SMITH: Can I ask a question of Jessin?

MR. POOLE: Yes. Go ahead, Rosemary.

MS. SMITH: Jessin, with the new single state PBM Medimpact, I know DMS, your Department has control of those contracts. And won't the contracts all be exactly the same for every pharmacy in Kentucky, and, then, you'll be able to look at those and you will be approving those? So there shouldn't be, am I correct, shouldn't be a no-audit contract? All of those should be uniform. Is that correct?

DR. JOSEPH: Right. No-audit contracts don't exist. Just like how the fee-for-service program works, once a pharmacy is enrolled with Kentucky Medicaid, you are enrolled in Kentucky Medicaid as a pharmacy provider.

That puts you - however you want to look at it - at risk within the same pool for an audit regardless of pharmacy type. And, again, we don't designate based off of pharmacy type in Medicaid.

MS. SMITH: Thanks. I thought that was true.

Until July 1, until the implementation of Senate Bill 50, we're kind of out there hanging, but I think I understand that that will be taken care of with the new Medimpact contracts.

MR. POOLE: Okay.

MS. STRAUB: This is Paula. Jessin, are we still looking at a 7/1 implementation date for Medimpact?

DR. JOSEPH: Yes.

MR. POOLE: And, Jessin, if you wouldn't mind, beings that question just got asked so we don't have to go back to it, if you just want to give us an update of what's happened over the last thirty to sixty days with choosing Medimpact and what's going on behind the scenes to get this implemented.

And, again, what I guess everybody's question is is that why can't we get it done earlier? I mean, that would be everybody's wishes, but I just wanted to give you an opportunity to update.

DR. JOSEPH: Sure. I don't want

to share too much because, again, we're working on a lot of things simultaneously. And, so, as we kind of get through them, it will take time to build out.

I'd like to at least address the concern around doing this quickly. Even in the commercial space, if a new PBM is coming to take over with a health plan, there would be more than a six-month time frame in the commercial space.

We're working through a number of regulations up front, and, then, at the same time, we're working through an operational standpoint.

So, this model is new. The fact that we're building up an entire benefit for 1.6 million lives I think is the one thing I try to stress to everyone is what we don't want to do is do things fast and not think things through.

We want to make sure that everybody is on the same page when it comes to operating this and standing this up.

So, there are concerns around making sure files are transferred appropriately, layouts are the same, information is uploaded accordingly, and, then, setting this up for an automated process.

So, to say that we could do

this in one or two months or really four or five months, it is a time-consuming process.

So, we are working for the 7/1 start date, and, again, I want to say that that hasn't changed at all; but the question to see if we can get this done sooner, I would be beyond belief if anybody can.

And, so, again, I know that's not necessarily the news everyone wants to hear but that is the truth.

In terms of updates, again, we're working on multiple things all at the same time. Conversations with CMS, the conversations with Medimpact are all ongoing. We are building this out.

So, anybody is more than welcome to shadow for a day but a lot of my time is now spent talking to Medimpact and figuring out what we necessarily need to get done ASAP and, again, for the 7/1 go-live date.

MR. POOLE: Okay.

MS. STRAUB: This is Paula again. I think I've sent you a couple of emails, Jessin, about a couple of issues that pharmacists relayed to me as far as DAW issues with Medimpact and, then, new pharmacies coming on board where

there's a waiting period and those are being addressed, correct?

DR. JOSEPH: I can talk on at least two of them. The DAW piece, again, we are designing the benefit, right? So, we would set this up prior to the go-live, whether or not DAW is necessary or where it isn't necessary.

The piece about the wait for enrollment, the wait for enrollment is really going to be dependent on the time frame of Kentucky Medicaid's Provider Enrollment.

So, that is who is going to create this network. Medimpact will not be creating our pharmacy network. They will be using the Kentucky Medicaid network.

And, so, I hope that alleviates your concern there. It's really just dependent on making sure licenses are up to date. Everything that we have within the fee-for-service program would translate over.

MS. STRAUB: Gotcha. Okay. Perfect. Thank you.

MR. POOLE: Any other discussion on Number 4, the audit process? Again, this is one of those topics that take on a lot of different

avenues and fingers. So, I think we can make, between now and the next meeting, we could come up with a bullet point of recommendations that would be fair, What we'd like to see in the marketplace that is more transparent and more fair is all we're asking.

So, does anybody care to take any action on that today or just let's be working on that?

MR. CARRICO: I think if we're all in agreement with what's on the agenda and kind of what's been voiced, which it sounds like we are, we know the direction to go, we can get a really better-sounding motion put together than we would today.

MR. POOLE: Okay. All right. Thanks. Any further discussion, then, on Item 4?

Hearing none, 5 was Medimpact encouraged to pay for low-cost OTC's because we're seeing in the marketplace now, Jessin, where a lot of OTC's are being taken off the formulary.

Obviously, I do a lot of nutritional consultations. So, I can just tell you that my autistic patients, they're not deficient in Risperdal or Prozac. They're deficient in

Glutathione and Taurine and Selenium and Zinc and Magnesium.

I've been a supporter of this measure for a long time. I work with physicians and I actually just donate to Medicaid patients because they can't afford just the nutritional supplements. I actually compound for them because most of them at age three to ten have texture issues.

So, I actually compound gels for them to just rub on their stomach or inner thigh and it seems to do wonderful. I've had a lot of verbal children that's been able to not be verbal and actually start forming words and sentences. So, I know it works.

So, this is kind of just near and dear to me because I wish there was a way to get the nutrients needed for these patients because they're just as important a lot of times in certain disease states as prescription drugs.

And, Matt, I know you're the one that actually put this on the agenda. So, I wanted to give you a chance to speak on it.

MR. CARRICO: I echo what you're saying about Medimpact.

Mine is more about it seems

like at the beginning of February, a lot of OTC's went off the formulary, and I get that they're supposed to be able to give rebates or whatever to be part of the CMS or Medicaid plan, but I'm going crazy trying to figure out which NDC's can bill.

There was one MCO patient I tried to bill for an Omeprazole tablet. It rejected. They gave me another NDC to try. I tried that NDC. It rejected. It gave me a third NDC to try and rejected. It gave me the first NDC that I tried that already rejected.

It's just really difficult to try to help people when you don't know what's going on or how to fix it. I'm just asking for help. Where can we go to find what is actually covered that is available because a lot of stuff is going unavailable at times.

Aspirins are off the market for two, three weeks at a time and then they're back on and, then, the ones you get aren't covered. It's just a case of a lot of OTC's and it's been really frustrating.

DR. JOSEPH: Matt, let me try to address some of it. And if any of the MCOs want to speak to it, they can as well.

The OTC products are not part of the PDL. The Preferred Drug List is a subset of all the drugs that Medicaid pays for. And, so, there are rules in terms of what we can pay for based off of what CMS dictates to us.

So, we've created a fee-for-service specific OTC list. Chairman Poole, I'm not sure if this is what you were referring to, but it is on our website what OTC products we cover.

Obviously, the MCOs will select their own OTC products. Prior to single PDL, they managed the entirety of the pharmacy benefit.

And, so, when we moved to the single PDL, there was a miscommunication that the MCOs essentially, some of the MCOs essentially did not have a supplemental file, if you want to say that, or a separate listing of drugs that are required to be - they had coverage - I'm sorry.

They had coverage, however, the misunderstanding was around prior authorizations or no prior authorizations. And, so, I think it's the terminology that led to the misunderstanding.

The formulary at the end of the day will be all of the drugs that we cover and we cover everything that is a covered outpatient drug

and that's a separate definition, but the PDL is just a subset of all of that.

And, so, at this time, I believe all of the MCOs have now corrected this. I think this was a big issue in January and, then, early February. Again, if there is still an issue out there, please let us know and, again, we can always direct it to the appropriate MCO for a fix.

Again, we're not going to necessarily dictate to them which OTC products they have to cover and which ones they don't because, again, they're not on the PDL, but I hear your concern and it was an issue and it's not something that was ever the intent here.

MR. POOLE: Okay. And a follow-up question would be, so, from what you're telling me, it wouldn't even do any good to go to the P&T Committee with testimony like the example I gave which is autistic children because it's not CMS' - CMS dictates what's on there.

DR. JOSEPH: Well, not to say that it wouldn't be a value. The value is more towards us, right? So, the P&T Committee is going to be specific to the PDL, the Preferred Drug List.

So, if there is concern on your

all's end regarding a product, then, certainly bring it to DMS' attention so we can address it from the fee-for-service side. We can relay this information to the MCO side, but the P&T Committee is going to be specific to the products on the PDL.

And, really, the agenda will be set beforehand. And, so, you're not going to see the OTC products on there, if that makes sense.

MR. POOLE: Okay. So, I will work on supplying some testimony.

DR. JOSEPH: Chairman Poole, we've started down the path of restructuring the entirety of our fee-for service OTC list. I anticipate that will go live 7/1. Obviously, right now, it's a little bit shorter. And if you look at the list, a number of products aren't on the market anymore.

So, we're making changes. So, again, if you have recommendations today, this week, next week, send them over and we'll certainly look into them and see which products are available.

MR. POOLE: Okay.

DR. MUDD: Ron, a quick question, if I may. Jessin, is there a place where pharmacists can go to make that recommendation

outside of sending you an email or a phone call? Is there like a web form somewhere because I'll use the example of Vitamin D.

It's a fun conversation to tell a patient, well, this is covered but the covered NDC is not available. So, if I could get the specific manufacturer, then, yes, I could dispense this to you but I can't get it.

So, is there one place that a pharmacy could go to to say, hey, I'm having trouble with this specific NDC for this MCO?

DR. JOSEPH: If it's specific for an MCO, you can certainly outreach to me and we can direct it to the appropriate MCO.

And, then, Dr. Mudd, again, this is kind of the forum where we can certainly discuss this as well, hey, this Vitamin D product, this NDC is not available. And, then, I would be glad to follow up and take a look into why that NDC isn't available or why, if there is an available NDC, why we don't cover it.

MS. BATES: Jessin, it's Stephanie. I would recommend that all providers go to the MCO first. I'm just kind of putting that out there because maybe the MCO can have - I don't know.

I'm curious what you just said. Do you ever go to the MCO first and what is that experience? I'd like to hear about that since they're on here and they can speak to it.

MS. STRAUB: I will tell you that I've reached out to all the Pharmacy Directors at all of these specific MCOs and they have been very helpful in getting me the certain products that are covered.

It would be nice if their supplemental PDL's had specific NDC numbers on their websites but they have been very helpful in getting me the products that are covered.

MS. BATES: And I'm just only putting that out there because Jessin is like only one human being who is also trying to set up a single PBM.

And, so, if the MCOs can step up and do that for him, that's really who needs to answer to any kind of issue anyway first.

DR. MUDD: That was I guess my request. Is there already a list of who, if the pharmacy had an issue with one MCO, is there a - I was just in practice a week ago and I didn't know who to call and we looked, but is there a place that we

can send a pharmacist and say, okay, this issue, email this person for this particular MCO?

MS. BATES: Yeah. I believe we have MCOs on here, and I don't see anything wrong with after this call getting with them. I'm going to pick on the very first one I see. Carrie Armstrong, do you want to answer?

MS. ARMSTRONG: Absolutely. I'm happy to provide contact information.. Anytime that you come across this situation, definitely let us know and we can absolutely look into it.

MS. BATES: What we'll do is we'll get - Angie Parker is on - and she will get with Jessin to put something out to the MCOs to get you all a contact list so you know who to contact first.

DR. MUDD: That would really be good.

MS. BATES: That way, you have it all in one document. And that way, if you run into issues to where you do call and you can't get a resolution, then, that's when you go to the Department and we take care of it.

There's no other way to say it. We pay MCOs to do this and to help you all and, so,

they need to do that.

DR. MUDD: If we can get that list together, that would be awesome. Thank you.

MR. POOLE: Stephanie, that would be really, really helpful to everybody.

In a related topic, Matt, on Number 6, if you just want to elaborate on your point there.

MR. CARRICO: Well, it seems to have resolved itself; but starting on February 1st, a lot of pain medications, Hydrocodone, short-acting opiates were not covered, and I was unaware of this. Other pharmacies I spoke to were unaware of this change. Patients were unaware of it. Doctors' offices were unaware of it.

So, they were questioning if we were right, and it created just pandemonium as you might assume where people were just like, well, I can't afford to pay for this or people getting mad at staff or people crying.

I talked to Jessin and it looks like it was some of the changes with the formulary for fee-for-service. However, with that said, I went back and looked at the customers that it affected today before this call and re-ran it, and whatever

the issue was must have resolved itself because everyone's prescriptions were covered as of today. So, I'll give a lot of refunds out in the next couple of days, but I guess this is taken care of at this moment but it was an intense first week of February, I can tell you that.

MS. STRAUB: This is Paula again. I think it was just a coding issue and they have resolved it. I think it was just a coding issue that's been resolved.

MR. POOLE: Thanks, Paula. Okay, Sharley, if you could move on down.

MS. HUGHES: That's it.

MR. POOLE: All right. If it's okay with everyone, two committee members can work together without a quorum.

So, these topics that we all discussed that we need to do some more work on, I'm going to send you all an email, and if you want to volunteer - and, again, I just need two per topic - and, then, if you could be our go-to person to get some more personnel just like finding some more resources for people who do sterile compounding, but I think if we can get enough people involved with each one of those, that it could make short work for

all of us.

And, then, of course, just send me your work on it and I think we can get it done without stressing too many people out to do several of these topics.

Does anybody have anything else to discuss that we hadn't with the agenda?

MS. SMITH: I think, Ron, there was one thing we had on the agenda that didn't populate, but we were going to maybe ask Jessin for just a status on the methodology payments that we had recommended.

MR. POOLE: Thank you for reminding me of that. Do you have any update on that, Jessin, our recommendation that was made for the pricing methodology, payment methodology?

DR. JOSEPH: I don't have a formal update. I think we're really close is the easiest way I can put it.

And, again, just a reminder for everyone, whatever the methodology is, we do have to submit it to CMS for approval, make sure that it is a regulation for the state. So, there should be I believe from a regulation standpoint a feedback period and all that.

Again, I will let you know as soon as I can but we are very close.

MR. POOLE: As a footnote to that, Jessin, if they want to pay us more, we're okay with that.

DR. JOSEPH: I'll let them know.

MR. POOLE: Do I have a motion to adjourn?

MR. CARRICO: Ron, I make the motion to adjourn,.

MS. SMITH: Second.

MR. POOLE: Any further discussion? All those in favor, say aye. Thank you.

MEETING ADJOURNED